



Facility Name & ID Number Hickory Point Terrace

# 0033068 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/12/91

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,661			5,661	13
14	TOTALS	5,661			5,661	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.93%

D. How many bed-hold days during this year were paid by Public Aid?

148 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO X

I. On what date did you start providing long term care at this location?

Date started 1/19/88

J. Was the facility purchased or leased after January 1, 1978?

YES X Date 1/19/88 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH\* CASH\*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/01 Fiscal Year:

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number      Hickory Point Terrace      #      0033068      Report Period Beginning:      1/1/01      Ending:      12/31/01

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	20,136	2,543	1,455	24,134		24,134		24,134			1
2	Food Purchase		39,387		39,387	(4,136)	35,251		35,251			2
3	Housekeeping	24,576	2,856		27,432		27,432	21	27,453			3
4	Laundry											4
5	Heat and Other Utilities			12,685	12,685		12,685		12,685			5
6	Maintenance	200	2,273	10,877	13,350		13,350	1,798	15,148			6
7	Other (specify):*			3,341	3,341		3,341	243	3,584			7
8	<b>TOTAL General Services</b>	44,912	47,059	28,358	120,329	(4,136)	116,193	2,062	118,255			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,270	7,270		7,270		7,270			9
10	Nursing and Medical Records	111,471	5,341	6,323	123,135		123,135	230	123,365			10
10a	Therapy											10a
11	Activities	18,484	10,868		29,352		29,352		29,352			11
12	Social Services	31,802	1,253	1,090	34,145		34,145		34,145			12
13	Nurse Aide Training	9,063			9,063		9,063		9,063			13
14	Program Transportation			4,373	4,373		4,373		4,373			14
15	Other (specify):*			134,622	134,622		134,622	(132,983)	1,639			15
16	<b>TOTAL Health Care and Programs</b>	170,820	17,462	153,678	341,960		341,960	(132,753)	209,207			16
	<b>C. General Administration</b>											
17	Administrative	114,419			114,419		114,419		114,419			17
18	Directors Fees											18
19	Professional Services			7,400	7,400		7,400	656	8,056			19
20	Dues, Fees, Subscriptions & Promotions			1,900	1,900		1,900	1,491	3,391			20
21	Clerical & General Office Expenses	25,106	3,122	18,323	46,551		46,551	(9,976)	36,575			21
22	Employee Benefits & Payroll Taxes			30,004	30,004	4,136	34,140		34,140			22
23	Inservice Training & Education							332	332			23
24	Travel and Seminar			1,763	1,763		1,763	2,042	3,805			24
25	Other Admin. Staff Transportation			2,013	2,013		2,013		2,013			25
26	Insurance-Prop.Liab.Malpractice			7,927	7,927		7,927	189	8,116			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	139,525	3,122	69,330	211,977	4,136	216,113	(5,266)	210,847			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	355,257	67,643	251,366	674,266		674,266	(135,957)	538,309			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			26,917	26,917		26,917	(2,676)	24,241			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,689	8,689		8,689	245	8,934			32
33	Real Estate Taxes			5,350	5,350		5,350		5,350			33
34	Rent-Facility & Grounds			46,800	46,800		46,800		46,800			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			87,756	87,756		87,756	(2,431)	85,325			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,415	36,415		36,415		36,415			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,415	36,415		36,415		36,415			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	355,257	67,643	375,537	798,437		798,437	(138,388)	660,049			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(132,983)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,928)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (140,911)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,523	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,523		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (138,388)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39	Therapy		X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Hickory Point Terrace

ID#

0033068

Report Period Beginning:

1/1/01

Ending:

12/31/01

NON-ALLOWABLE EXPENSES

Amount

Sch. V Line  
Reference

1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

<b>Facility Name &amp; ID Number</b>	<b>Hickory Point Terrace</b>	<b>#</b>	<b>0033068</b>	<b>Report Period Beginning:</b>	<b>1/1/01</b>	<b>Ending:</b>	<b>12/31/01</b>
<b>SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I</b>							

[illegible]





VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kimberlea B. Jacobus	100	Kimberlea B. Jacobus d/b/a North Kickapoo	Lincoln, IL	Kim Jacobus		Central Office
	0	ITOS d/b/a Spring Creek Terrace - Non-Profit Corp.	Decatur, IL	Central Office	Decatur	for homes

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	General Office	\$14,000	Kimberlea Jacobus, Central Office	100.00%	\$4,024	\$ (9,976)	1
2	V	3	Housekeeping				21	21	2
3	V	5	Utilities				0		3
4	V	6	Maintenance				1,798	1,798	4
5	V	7	Other				243	243	5
6	V	10	Medical Supplies				230	230	6
7	V	19	Professional Fees				656	656	7
8	V	20	Licenses/Dues				1,491	1,491	8
9	V	23	Training				332	332	9
10	V	24	Seminars				2,042	2,042	10
11	V	26	Insurance				189	189	11
12	V	30	Depreciation				5,252	5,252	12
13	V	32	Interest				245	245	13
14	Total			\$14,000			\$16,523	\$ *2,523	14

Facility Name & ID Number      Hickory Point Terrace      #      0033068      Report Period Beginning:      1/1/01      Ending:      12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Kimberlea B. Jacobus	Owner	Administrator	100.00	162,390	14	33.33	Adminstrator	\$ 114,419	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 114,419		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Soy Capital Bank		X	2000 Dodge Ram B2500	\$606.60	2/21/01	\$ 19,216	\$ 13,853	2/21/04	8.5000	\$ 1,310	1
2	Soy Capital Bank		X	2000 Land Rover	\$1,605.85	1/12/01	35,454	18,517	1/2/03	8.3510	2,333	2
3												3
4												4
5												5
	Working Capital											
6	National City Bank		X	Operating Cash	N/A	6/30/01	200,000	126,000	6/30/02	4.7500	5,046	6
7												7
8												8
9	TOTAL Facility Related				\$2,212.45		\$ 254,670	\$ 158,370			\$ 8,689	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 254,670	\$ 158,370			\$ 8,689	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

12/31/01

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.	\$	<b>5,300</b>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>5,195</b>	2	
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(105)</b>	3	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>5,455</b>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For 19      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>5,350</b>	7	
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	<b>5,090</b>	8	
	1997	<b>4,700</b>	9	
	1998	<b>5,031</b>	10	
	1999	<b>5,048</b>	11	
	2000	<b>5,195</b>	12	
<b>2001 Accrual based on 2000 taxes</b>				

		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Point Terrace COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0033068

CONTACT PERSON REGARDING THIS REPORT Kimberlea B. Jacobus

TELEPHONE 217-422-6361 FAX #: 217-422-6365

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 07-07-23-101-005	Building and Land - .96 acres	\$ 5,195.32	\$ 5,195.32
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 5,195.32	\$ 5,195.32

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,030 B. General Construction Type: Exterior Brick/Vinyl Frame Wood w/Sprinklers Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (X) (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).  
N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO  
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:  
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping		1992		2,255	133	10	226	93	2,087	9
10	Shower Unit		1992		563		10	56	56	515	10
11	Vinyl Flooring		1993		4,511		6			4,511	11
12	Flooring		1994		2,858		6			2,858	12
13	ASE Blacktop		1994		5,000	295	15	333	38	2,527	13
14	Electrical Improvement		1995		1,714	44	10	171	127	1,199	14
15	Carpet		1995		3,326		10	333	333	2,079	15
16	Fire Extinguisher		1995		614		10	61	61	378	16
17	Landscaping		1996		2,418	151	10	242	91	1,330	17
18	Flooring		1997		1,699		10	170	170	765	18
19	Roof		1998		10,200	261	20	510	249	1,657	19
20	Floor Covering		2001		2,746	2,746	10	252	(2,494)	252	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total  
SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$37,904	\$3,630		\$2,354	\$(1,276)	\$20,158	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$38,681	\$230	\$2,855	\$2,625	3-20 yrs	\$21,965	71
72	Current Year Purchases	2,172	2,172	109	(2,063)	10 yrs	109	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$40,853	\$2,402	\$2,964	\$562		\$22,074	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Transportation	1996 Dodge Ram	1996	\$Traded	\$1,775	\$	\$(1,775)	4	\$	76
77	Transportation	1990 VW Cabriolet	2000	3,214	677	804	127	4	1,071	77
78	Transportation	2000 Land Rover	2001	35,455	3,060	8,864	5,804	4	8,864	78
79	Program Transportation	2000 Dodge Ram	2001	41,861	15,373	4,003	(11,370)	4	4,003	79
80	TOTALS			\$80,530	\$20,885	\$13,671	\$(7,214)		\$13,938	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$159,287	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$26,917	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$18,989	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(7,928)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$56,170	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Scott Cornell
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☒ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1988	16	05/01/93	\$ 46,800	15	0	3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$ 46,800			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 
- 

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES  
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☒  
IN OTHER FACILITY☐  
COMMUNITY COLLEGE☐  
HOURS PER AIDE39

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐  
IN OTHER FACILITY☐  
HOURS PER AIDE

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		9,063		9,063
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 9,063	\$	\$ 9,063
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,063			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 14,529	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	140,646		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,092		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 158,267	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	37,904		15
16	Equipment, at Historical Cost	121,381		16
17	Accumulated Depreciation (book methods)	(100,379)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 58,906	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 217,173	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 4,067	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	148,808		29
30	Accrued Salaries Payable	8,718		30
31	Accrued Taxes Payable (excluding real estate taxes)	611		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,455		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 167,659	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	9,562		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 9,562	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 177,221	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 39,952	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 217,173	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 40,573	1
2	Restatements (describe):		2
3	Rounding	(14)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 40,559	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(13,454)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (13,454)	17
	B. Transfers (Itemize):		
18	Auto Loan Reimbursement	12,847	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 12,847	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 39,952	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 625,944	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 625,944	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education	146,281	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	12,758	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 159,039	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 784,983	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	120,329	31
32	Health Care	341,960	32
33	General Administration	211,977	33
	<b>B. Capital Expense</b>		
34	Ownership	87,756	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	36,415	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 798,437	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(13,454)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (13,454)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	500	500	7,705	15.41	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	11,667	11,811	103,766	8.79	5
6	Nurse Aide Trainees	1,108	1,108	9,063	8.18	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,753	1,753	15,498	8.84	9
10	Activity Assistants	449	449	2,986	6.65	10
11	Social Service Workers	1,859	1,859	31,802	17.11	11
12	Dietician	2,251	2,331	20,136	8.64	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers			200		17
18	Housekeepers	2,773	2,824	24,576	8.70	18
19	Laundry					19
20	Administrator	728	728	114,419	157.17	20
21	Assistant Administrator	626	626	17,499	27.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	791	791	7,607	9.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,505	24,780	\$ 355,257 *	\$ 14.34	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	43	\$ 1,455	1-3	35
36	Medical Director	Fee	7,270	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Fee	1,700	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	43	1,923	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10-3	43
44	Activity Consultant				44
45	Social Service Consultant	Fee	1,090	12-3	45
46	Other(specify) <u>Psychologist</u>	Fee	2,700	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	86	\$ 16,138		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Kimberlea Jacobus	Administrator	100	\$ 114,419	Workers' Compensation Insurance	\$	3,721	IDPH License Fee	\$
				Unemployment Compensation Insurance		4,782	Advertising: Employee Recruitment	1,900
				FICA Taxes		16,542	Health Care Worker Background Check	
				Employee Health Insurance		3,399	(Indicate # of checks performed )	
				Employee Meals		4,136	Central Office advertising	1,465
				Illinois Municipal Retirement Fund (IMRF)*			Central Office license & fees	26
				Simple IRA Match		1,560		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 114,419					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
			\$				Less: Public Relations Expense	( )
							Non-allowable advertising	( )
							Yellow page advertising	( )
							TOTAL (agree to Sch. V,	\$ 3,391
							line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
May, Cocagne & King, P.C.	Accounting/Bookkeeping		\$ 7,400	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	1,763
							Central Office Seminars (All in Illinois)	2,042
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)			\$ 7,400	TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)							line 24, col. 8)	\$ 3,805

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount.
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease.
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 36,415  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,136 Has any meal income been offset against related costs? No Indicate the amount. \$
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients? 100%

d. Have vehicle usage logs been maintained? Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Kimberlea B. Jacobus #0033068  
d/b/a Hickory Point Terrace  
December 31, 2001

Documentation - Section V, Line 7, Column 3:

Waste Removal	1,084
Pest Control	377
Security	1,880
	<u>3,341</u>

Documentation - Section V, Line 15, Column 3:

Workshop	132,983
Emergency Dental Care	1,565
Optical Care	54
Podiatry Care	20
	<u>134,622</u>

Documentation - Section V, Line 24, Column 8:

Seminars and meetings	<u>3,805</u>
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All seminar expenses were for continuing education units (CEU's) for employees relating to patient care. All seminars were attended in Illinois.

Documentation - Section V, Line 30, Column 7:

Straight-line adjustment (page 13, line 84)	(7,928)
Central Office	5,252
	<u>(2,676)</u>

Reclassifications - Section V, Column 5:

	From Line #	To Line #	Amount
Employee Benefits (Staff Meals)	2	22	4,136

Page 7, ScheduleVII, C., Related Parties  
Column 5, Compensation Received from Other Homes

<u>Kimberlea B. Jacobus</u>		
ITOS d/b/a Spring Ckreek Terrace Decatur, Illinois		110,290
North Kickapoo Lincoln, Illinois		<u>52,100</u>
		<u>162,390</u>

Section XI, D., Vehicle Depreciation

The 1996 Dodge Van was traded in for the 2000 Dodge Van. The trade was reported Pursuant to IRS Notice 2000-4, which requires the old asset to remain on the books until it is fully depreciation. The cost for the 2000 van includes original cost of the 1996 van plus the cash (boot) paid during trade-in. Schedule attached to reflect the costs.

Section XVII, Reconciliation of Income to Taxable Income:

Net Income (Loss) Per Books	(13,454)
Auto Loan Reimbursement	12,847
Administrator's Salary	<u>114,419</u>
Net Income Per Tax Return	<u>113,812</u>

Section XX, General Information, Question 12:

Salary costs are allocated based upon actual hours worked.